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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

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## Original Communications.

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### IMPAIRED SIGHT AND ITS CAUSES.\*

BY E. WILLIAMS, M. D.

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Strictly, that which is and ever has been imperfect sight can not be called impaired so long as it remains the same. But imperfect as well as standard vision may be impaired by disease. The causes of such impairment are extremely numerous. We must exclude from the list such as are due to natural physical defects and to physiological changes from age. Anomalies of refraction, due to defects of form in the eye, will give greater inconveniences as we grow older and the tissues stiffen. Age, acting on all eyes, will tell much earlier and more seriously on persons with defective refraction. These are hyperopia and hyperopic astigmatism.

Such optical defects, if not excessive, so long as the lens is soft and yielding, may be overcome by exaggerated efforts of accommodation, and sight unconsciously kept at standard. But loss of strength from weakening disease, or paralysis of the ciliary muscle in diphtheria, or excessive close use of the eyes, will lead to sudden and great failure of vision. In congenital

\*Read before the Mitchell District Medical Society, Seymour, Indiana, December 28, 1883.

defects of refraction, not only reading power ceases, but sight becomes much worse even for distance. Convex lenses of adequate strength will restore perfection to both. With recovery satisfactory vision returns, and the glasses may be laid aside. In these anomalies, simple overuse of the eyes may lead to sudden failure.

In such event the eyes, previously good, suddenly let down, and become painful on close application. Persistence increases the pain and glimmering, and the patient is forced to stop, close and rub the eyes, and rest. In a few moments the print is again clear. But a return to study leads again and again to feelings of fatigue, pain, and dimness. The woe-be-gone feeling of the eyes, pain, spasm of the lids, redness of the conjunctiva will alarm the patient and compel him to quit school or close work. If the family physician sees evidences of *threatened amaurosis*—shuts the patient in the house, excludes light, and enforces the antiphlogistic regimen and treatment—a reign of terror is inaugurated that grows more terrible all the time. Should he diagnose granulated lids, and subject his victim to repeated blisters and cauterizations, he sets up a reign of rage. An intelligent recognition of the optical cause of the trouble, and a judicious use of correcting glasses are all that is needed.

Both accommodative and muscular asthenopia are common causes of trouble, and often of alarm, to both patient and physician. In all such difficulties, with the satisfactory use of the eyes, a discriminating diagnosis will save the patient much suffering, the attending physician much mortification, and the profession from the charge of ignorant cruelty to animals. The diagnosis of granular lids is very easy, but a persistent hyperemia of the conjunctiva may more readily be mistaken for chronic conjunctivitis. When rest of the eyes, avoidance of irregularities and exposures and mild local treatment fail to effect any improvement, the presumption is that some anomaly of refraction, or insufficiency of the internal or external recti muscles, is the secret of difficulty.

People are ever ready to take up a reference to optic-nerve



trouble, if the symptoms are painful, or paralysis of the optic nerve, if they are not; and physicians should be careful how they refer such asthenopic symptoms to such grave and alarming causes. Instead of optic neuritis and acute troubles of the retina being attended by pain, they are seldom, if ever, seriously painful, and direct paralysis of these parts is extremely rare.

The word amaurosis in pre-ophthalmoscopic times—used to designate all serious defects of sight from causes behind the lens—is now almost discarded by ophthalmologists. They use it only to indicate the very few cases of impaired or lost sight where neither the eye-mirror nor any other means can detect a lesion sufficient to account for it. Amaurosis and catarrh have been played upon, like a harp of a thousand strings, by the profession till people are frightened out of their senses when they hear the name. Of course the buzzards of our craft can scent such cases from afar and send them circulars, like the expert angler fastens the bit of red flannel on his hook and skips it so temptingly on the water.

Another popular error is that myopia is not a disease or the result of disease, and that it improves as the patient grows older. Nearsightedness is due to a permanent change of shape in the globe of the eye, and is sure never to grow better, but very liable to increase. Progressive myopia is a disease which is constantly liable to become complicated by choroiditis, corpuscles in the vitreous detachment of the retina, and many other serious troubles. The so-called second-sight is explained simply by the development of myopia in advanced years, and just in proportion as reading capacity, without convex glasses, is restored will the vision in the distance become more and more defective.

In testing for perfection of vision, the sight should, be tried first for distance—say fifteen to twenty feet. Snellen's test letters and types are so arranged that each line, at its given distance, is seen under an angle of one minute, that being adopted as normal vision. If No. 15 or No. 20 can not be read, in an average light, at fifteen or twenty feet, the degree of visual deficiency

may be determined and recorded at once. Each eye should be tried separately. In slight degrees of astigmatism, the vision is usually little, if any, below the standard; but in higher degrees the uncorrected sight is always very imperfect. With these persons no sphericals, positive or negative, can bring it up, but cylindrical lenses will help greatly. If the unaided sight is not normal and can not be made so by any glasses, we then begin the investigation for other causes. These preliminaries will enable you to understand what we mean by impaired vision and help in the intelligent study of its various causes. If the failure is sudden, and due to severe inflammation, its detection is usually easy. If very insidious in its development, a more careful and thorough examination must be made. It will help the study if we remember that sight may be damaged from disease in the eye itself; from morbid changes in the optic nerve or tract connecting it with the brain; or from disturbances in the brain or spinal-cord, or both.

But, as I wish to adapt my paper to the practical wants of medical men, I shall confine myself to the discussion of a few of the commonest and often preventable causes of impaired or lost sight.

A man in promiscuous practice must know, at least, enough of eye diseases to detect their existence, and decide promptly if the case requires the skill of an expert. Otherwise those that trust him for advice may suffer irreparable damage. While the ophthalmoscope should be familiar to every physician as an instrument of precision in the diagnoses of other diseases than those directly involving the eye, there are many very common causes of damage to vision where it is not needed at all. In acute inflammation of the cornea and iris it is not necessary and its use often precluded. How often is iritis mistaken for *sore eyes*, and treated by heroic astringents till irreparable damage is done! The failure of diagnosis is here particularly unfortunate because irritating treatment aggravates and increases the danger. Then again valuable time is lost before proper treatment is instituted. *The danger* in all cases of acute plastic iritis is that the

iris will become agglutinated to the capsule of the lens, the pupil closed by false membrane, and all communication perhaps between the anterior and posterior aqueous chambers cut off. This extreme lesion can hardly fail to lead to other diseases in the future that will totally destroy sight. Prompt diagnosis and the energetic use of the sulphate of atropia from the very beginning will generally prevent such lesions. Of course, the constitutional state of the patient must be studied and treated, but the demand for promptness in the use of the local remedy is first. For the correct diagnosis of this disease, so easily managed in its first stages, the objective symptoms of extreme contraction of the pupil and its sluggishness to altered degrees of light, with the discoloration and loss of the natural fibrous and brilliant appearance of the iris, the more or less turbidness of the aqueous humor, and the crucial test for adhesions with the local use of atropine, are conclusive. Then, if you add the so uniform subjective symptom of severe pain in and especially around the eye, your decision is positive. A syphilitic history or rheumatic tendency, often present, only help to confirm. Of course some conjunctivitis will be present, but the primary and chief disease is in the iris, and that *only* needs intelligent recognition and treatment.

Inflammation of the cornea is also a very common source of impaired vision. The differential diagnosis is here extremely easy. Opacities from infiltration, abrasions of the epithelium, ulceration, vascularity, with great photophobia are the characteristic features. With the intolerance to light, we necessarily see weeping and spasmodic closure of the eyelids. In the phlyctenular keratitis of scrofulous children the photophobia is so intense and persistent that the objective examination of the cornea is very difficult. But it must be done. Astringents, often prescribed flippantly by the family physician, always do harm here also. If a solution of acetate of lead is used, indelible crusts will probably be added to the permanent opacity and impairment of sight.

Purulent conjunctivitis is a very common cause of damage

to sight. In the beginning even, the diagnosis is simple. But when the free suppurative stage sets in, he that runs may know the disease and its probable cause. This is strictly a self-limited disease. With decent care it always gets well, even without treatment. But the fact, never to be forgotten, is that the cornea is in imminent danger of destruction all the time it lasts. So *that* is the organ to rivet the attention of the physician. In adults, especially when gonorrheal, it is much more dangerous to sight than in infants.

It is the most acute and dangerous form of conjunctivitis, and yet only dangerous to the integrity of the cornea. In the immense majority of cases it is the result of contagion. The contagious principle is pus, and this is often secreted by an inflamed urethra. When that is the known source of the poison, it is properly called gonorrheal ophthalmia—self-inoculation by the fingers, in adults, and contact with the diseased secretions of the vagina, in the infant, is the ordinary solution of the problem. Still this disease may be, and sometimes is, the result of other intensified causes of conjunctivitis, as cold and exposure. This is particularly apt to be the fact where the eyes were already inflamed and perhaps granulated before the exposure. It is not scientific or charitable to assume that every person who suffers from purulent conjunctivitis must have contracted it from gonorrhea. Neither must it be inferred that the mother of every infant that becomes affected is the victim of criminal disease. A simple leucorrhea may be the cause of the contagion.

In a work just published, on "Blindness, Its Causes and Prevention," by Dr. Hugo Magnus, of Breslau, there is a graphic representation of the comparative frequency of blindness from different causes. It is based on the exact history of two thousand five hundred and twenty-eight cases of blindness in both eyes. Below the highest column stands blennorrhea neonatorum, nearly eleven per cent of the whole! The next highest is trachoma and blennorrhea of adults, about nine and one half per cent! Then follows glaucoma, 8.97 per cent; diseases of the cornea, 8.06 per cent, and so on. In view of these statistical

facts, confirmed by reports from the blind asylums of the world, what is the duty of the medical profession in the premises? To prevent the occurrence of purulent ophthalmia in grown people, and thus save sight, is not a promising field for benevolent work. Unless people could be radically reformed in their dirty and immoral habits, the sources of supply will continue to run on. As there are no alarming evidences in the existing state of society of the near approach of the millennium, neither is there any very hopeful prospect of the euthanasia which has been the hope of the medical profession for thousands of years. When that happy time comes, that the laws of health shall be fully understood and implicitly obeyed by every body, our calling will no longer be needed. The painful wail of the infant when ushered into the world will be replaced by a jolly laugh, and the death of the extremely old will be so natural that men will die naturally and easy! It will even be a pleasure to expire, as the new word indicates! But as yet there are still urgent calls for missionaries and for medical advice!

Our knowledge, however, enables us to prevent the most destructive disease to eyesight in infancy—that is ophthalmia neonatorum. For more than twenty years I have instructed my classes to have every new-born child's eyes immediately washed with clean, tepid water, before it is washed bodily. When the lids and brow are clean, a stream of tepid water must be passed through the eyes to remove every possible poison. If there is any suspicion of leucorrhea in the mother, and still more so, if she is known to have gonorrheal discharge, a two-grain solution of nitrate of silver must be dropped freely into the eyes after washing. The lids should be lifted from the ball, so that the solution comes freely in contact with the entire conjunctiva. It produces but little pain or reaction, and may be repeated twice a day for a couple of days in case of known danger. In most instances, one application is enough. Recent experiments of this kind, in large lying-in hospitals in different countries, have settled the question of thus preventing purulent conjunctivitis. If, as rarely occurs when these precautions are thoroughly car-

ried out, a case should develop, it proves very mild, and is easily cured. By such preventive measures, thousands of eyes may be annually saved from damage, and even total blindness. Prevention is certainly better than cure, but cure in these cases is almost certain by prompt and thorough treatment. I do not recall the loss of a single eye of an infant, in my experience of twenty-five years, when I saw it before the cornea was involved. Repeated cleansing of the eyes by opening them and mopping away the pus with dry absorbent cotton, and daily mild cauterizations with a ten-grain solution of nitrate of silver, overcomes this dangerous process in a few days, and greatly shortens the period of danger to the cornea. Great care should be taken to thoroughly evert the lids, and to protect the cornea from contact with the solution. After a few seconds the everted lids are freely washed off with tepid water. In the intervals, day and night, nothing is needed but frequent cleansing from matter, and a solution, once an hour, of biborate of soda.

The wash may be five grains to the ounce, freely dropped into the eyes after removing the pus. In adults, strict confinement to bed, ice compresses often changed day and night for a week or more, purgatives, leeches, free opiates at night, and a five-to-ten-grain solution of borax dropped into the eyes every hour, with atropine wash to relieve pain, are the best known means of saving the cornea. For the first few days, when the pain, phlegmonous swelling and heat are great, strong solutions of nitrate of silver to the everted lids are likely to do more harm than good. But this is not so in infants. In adults when there is profuse suppuration, after the acute period has somewhat abated, careful cauterizations will be tolerated and do great good. If a grown patient is seen, when but one eye is affected, the other may be successfully protected from contagion by hermetically sealing it up with cotton and collodion. This disease is much more dangerous in adults, and more refractory to treatment, than in the new-born. In all cases of purulent conjunctivitis, a *weak* solution of nitrate of silver, one or one half grain to the ounce, may be safely and frequently used as a wash, dropped freely into



the eyes every hour or oftener. In this strength it will hardly be felt, and can not injure the epithelium of the cornea. I am not at all sure that solutions of boracic acid, now so much in theoretical vogue, have any beneficial influence on conjunctivitis. The best that can be said of them is that they do no harm.

It is a great thing to be sure that ophthalmia neonatorum, the fell destroyer of the eyes of infants, can be prevented. Granulated eyelids, with their persistent and destructive relapses, may be prevented from spreading to others by careful isolation and cleanly precautions. Strict attention to the hygienic surroundings of such patients, to bathing, ventilation, change of clothing, exercise in the open air, diet, etc., with mild and prudent local treatment, will save many from life-long worry and partial or total loss of sight.

Another frequent cause of impaired sight is glaucoma. Early diagnosis and prompt resort to surgical treatment, constitute almost the only hope of saving vision.

Eserine in solution, dropped into the eye twice a day, relieves the increased tension of glaucoma and sometimes, but rarely, effects a permanent cure. Atropine has the opposite effect, increasing intraocular tension and its dangers. Not infrequently an attack of glaucoma dates from the local use of this substance. In all cases where symptoms of glaucoma are present, or are feared, the use of atropine or other midriatics should be carefully avoided. Glaucoma is essentially a disease of advanced years. When it occurs before forty or fifty years, it is nearly always secondary to injuries of the eye, closed pupil from iritis, ulceration and perforation of the cornea with synechia anterior, luxated lens or some other lesion. Primary glaucoma is confined to old people, where the coats of the arteries and capillaries have lost their elasticity. While observers are still not at accord as to the pathology of this fatal disease, there is a general agreement as to the unmistakable symptoms and the necessity of a surgical operation for the sake of permanent relief of the increased tension. Without this, hopeless blindness is inevitable. The earlier a surgical operation, iridectomy

or sclerotomy, is resorted to, the better the chance of saving useful vision. In chronic glaucoma, with deep cupping of the optic disk, marked contraction of the field of vision and great impairment of sight, it will be better to refrain. Likewise in the most fatal form, hemorrhagic glaucoma, iridectomy is almost sure to cause the immediate loss of sight. Where the eye is already sightless no operation is justifiable except to relieve harrassing pain. Then a sclerotomy may be risked, but enucleation is safer and surer. Preparatory to the iridectomy eserine may be used for a few days, if the symptoms are not very urgent. If it contracts the pupil, with temporary benefit to vision, it not only facilitates the operation but increases its promise of success.

The two most common causes of impaired vision in advanced age are cataract and glaucoma. The moment such a patient applies for advice, one or the other or both of these diseases combined should be suspected. When tested for manifest hyperopia by convex glasses, without benefit to sight, the certainty of this opinion is greatly increased. Even without the ophthalmoscope, with the characteristic cupping of the optic papilla and spontaneous pulsations of the retinal arteries the differential diagnosis is not usually difficult. With cataract the pupil will be small and prompt in its response to light and dark. In glaucoma it is sure to be dilated and sluggish to the action of light, if it acts at all. In cataract the degree of impairment of sight is in proportion to visible alterations in the transparency of the lens. With glaucoma, this condition is reversed. The large sub-conjunctival vessels are dilated, tortuous, and inosculate freely around the margin of the cornea in glaucoma, similar to the varicose veins on the surface of the belly in abdominal dropsy. Besides the dilated and sluggish pupil, the iris is atrophied and changed in color from absorption of its pigment, in glaucoma. Then the most characteristic symptom is increased hardness of the eyeball. The educated fingers soon learn to detect this increased tension. In cataract the changes in the lens are directly visible, especially by the aid of oblique illumi-



nation, with the pupil dilated by atropine. In many cases of cataract the sight is improved by artificial dilatation. On the contrary, it is uniformly worse after the use of atropine, and often the pain and tension are alarmingly increased by it, with glaucoma. If both exist together, as they often do, the perception of light, projection, and sight, if any is left, are too much reduced to be due to simple changes in the lens. However mature the cataract may be, ready perception of light and quick judgment as to its direction, will always be found in simple cataract. In this functional test of the retina the room should be darkened and a lighted candle used. If it is quickly detected fifteen or twenty feet away, the light being alternately darkened and uncovered, there can not be confirmed glaucoma. In this investigation the eye not examined should be well covered; then, keeping the gaze fixed in one direction, the covered light is silently removed toward the different sides. When uncovered, he should be able to point to the light without turning the eye toward it. If he can do this readily in all visible parts of the field, his projection is good.

In the absence of these two evidences of functional activity in the retina, an operation for cataract would be inexcusable. But a few weeks ago a poor man with glaucomatous cataract was brought to me for operation by his physician. When led into the room with head up and eyes wide open, he was looking to heaven for light which he could not discern. Should cataract be taken for glaucoma, and an iridectomy made, the case is not damaged for final extraction; but the reverse, with advice to wait quietly till blind enough for operation, is a fatal mistake, and, in the present state of diagnostic science, unpardonable.

People of apoplectic habits, with atheromatous degeneration of the coats of the blood-vessels, sometimes find sight in one or both eyes suddenly failing. A general cloudiness of all objects, with floating shadows as the eyes are moved, coming on suddenly, indicates intraocular hemorrhage. Of course, the ophthalmoscope will be necessary for a critical examination and diagnosis. If the patient has had *causeless* ecchymosis under

the conjunctiva, or symptoms of vertigo and mental confusion, there is danger not only for sight but for life. Indeed, intra-ocular hemorrhages have often led me to fear apoplectic attacks, too often realized. In old people of full habit, even a sub-conjunctival hemorrhage, an occurrence harmless in itself, will lead an enlightened physician to adopt precautions against central and more serious trouble.

In endocarditis or arteritis, and in women exhausted by puerperal hemorrhage, a coagulum may drift into the main artery of the retina and cause instantaneous blindness. Recovery of sight after such accident is almost impossible. Neoplasms in the cavity of the cranium are often attended by great swelling of the optic papilla, usually in both eyes, tortuosity of the retinal veins, hemorrhages, and other important diagnostic symptoms. The sight is always somewhat impaired in such cases, but not necessarily in proportion to the recognized changes in the optic nerve and retina. In albuminuria the diagnosis is often made with the ophthalmoscope before the disease had been suspected from other symptoms. The changes in the region of the macula lutea in this disease are so peculiar as to be almost pathognomonic.

A woman advanced in pregnancy, who complains of failing sight, at once arouses suspicion of albuminuric retinitis. If the diagnosis is settled by the ophthalmoscope, that patient is in imminent danger of puerperal convulsions, and should be treated with the greatest promptness and skill. In order to cure or prevent, the physician must know. Early and intelligent recognition of disease, even if it is not preventable or curable, rightly gives confidence in the medical adviser. I have dwelt upon these few of the many causes of impaired vision, because they are the most commonly met with in general practice, and are often directly or indirectly preventable.

CINCINNATI, OHIO.

A KNIFE-WOUND OF THE INTESTINES—ABDOMINAL  
CUT ENLARGED—THE GUT SUTURED—  
RECOVERY.

BY W. O. ROBERTS, M. D.

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Mr. —, a stout man, aged fifty-four years, while in an altercation, August 28, 1883, was cut in the abdomen with a pocket-knife. The wound was on the left side and was three inches long—extending obliquely from a point three inches to the left of and two inches above the umbilicus. It had opened the cavity and penetrated the small intestine. A considerable knuckle of the gut at once protruded and there was much hemorrhage. The wound was dressed soon after by a physician who was near by. Dr. Turner Anderson, Mr. —'s family physician, now saw the patient, and had him removed to St. Joseph's Infirmary, where Dr. Palmer saw him with Dr. A. Considerable bleeding having occurred on the way and there being some bulging about the wound, I was sent for. It was quickly agreed among us that the sutures should be removed, the wound opened and the bleeding vessel sought for. Dr. D. W. Yandell was then added to the consultation, and concurring in our views, the operation was proceeded with. It was now midnight. The patient took chloroform. The sutures, which were found to embrace but the skin and superficial fascia, were removed, and the wound extended at its two ends so as to admit the hand freely. A large coagulum of blood was seen lying just underneath the abdominal walls. This was removed and the intestines carefully drawn out until the cut portion was brought into view, when it was found that, in addition to slitting the gut, the knife had penetrated the great mesentery in two places, each an inch in length. One of these was occupied by a clot and was not bleeding. In the other bleeding was going on rapidly from three small vessels. Catgut ligatures were immediately thrown around these, and the hemorrhage ceased.

The wounded bowel proved to be the jejunum, and, fortunately, was empty. The physician who first saw the patient had put interrupted sutures in the cut bowel, two in the larger and one in the smaller cut, but in neither was the opening closed. On removing the sutures one slit was found to be the size of a common lead pencil, the other that of a pea. Both extended into the gut. The knife had stripped off the serous coat of the tube over the space of an inch by one quarter of an inch, and this had retracted toward one of the lips and lay there.\* In this denuded area, from which blood oozed freely, were the two bowel cuts. I secured the lips of both these cuts and the wound of the serous coat with continued sutures of catgut. When completed it was found that the stitches had considerably diminished the caliber of the tube, but not, it was believed, to an extent which would interfere with its functions. The peritoneal cavity was now well exposed to view by the aid of a mirror and thoroughly cleansed with sponges made hot in carbolized water; the intestine was returned; the external wound was closed by deep sutures of silk carried through the parietal peritoneum and the more superficial surfaces approximated by sutures of horse-hair. A drainage-tube of gutta-percha was left in the lower angle of the wound, and the entire abdomen was covered by a thick layer of absorbent cotton which was secured in place by a broad flannel bandage. A quarter grain of morphia was given hypodermically, the patient placed in bed and surrounded by bottles of hot water. It was now one o'clock in the morning. The patient's pulse was 108 and temperature in axilla  $97.5^{\circ}$  Fah. He slept well for six hours. On waking his pulse was 102, temperature  $99.6^{\circ}$ , respiration 28; no pain, no nausea. Some bloody fluid had come through the drainage-tube, soiling the cotton over a space

\*I am aware that in all wounds of the kind I am describing, there is always considerable retraction of the peritoneal coat of the tube, giving the appearance to the underlying tunic of having been peeled; but the surface exposed in this case was so much larger than is usual, that I must believe the peritoneal coat had been more than simply cut, and that a portion of it had been actually dissected up by the knife. The medical gentlemen present concurred with me in this opinion.

as large as the hand. The soiled portion only was removed and replaced by fresh cotton, and the bandage reapplied. For five days the progress of the case was altogether satisfactory—the pulse falling to eighty, the temperature remaining under  $100^{\circ}$ , and a quarter grain of hypodermic morphia every four or six hours securing comfort and sleep. No fluid came any longer through the drainage-tube, and it was removed.

During this time no food whatever had been given. Water was allowed in small quantities, iced champagne when asked for, and crushed ice, of which he took a good quantity, *ad libitum*.

On the evening of this day—the 5th—the patient complained of nausea, and during the night vomited several times. The ejecta had a suspicious though not a positive fecal odor, but during the sixth day they became distinctly stercoraceous. The temperature, which had fallen to normal, and pulse were unchanged. On removing the dressing the abdomen below the wound was of normal fullness—above it was much distended and distinctly tympanitic. There was no tenderness except immediately about the wound, and there really only at the seat of the two upper deep sutures, at which several small abscesses had formed. The hypodermic morphia was changed to a suppository containing the same amount along with a quarter grain also of belladonna, used every four or six hours. In the evening a quart of soap-suds was thrown into the rectum, but soon came away, bringing no feces and but a small quantity of gas. Abdominal features remain unchanged. Patient complains of the fullness of the stomach, has constant nausea, great thirst, and vomits after drinking water, the ejecta being of a deep yellow color and distinct fecal odor. The night was passed much as the day had been. On the morning of the seventh day castor oil was given by the mouth, in order to determine, if possible, whether the intestinal tube was closed or not. Two hours after the patient had a small action in which the oil globules were plainly visible. A hot water enema was now given, which was soon followed by a

copious dejection along with much gas. The nausea and vomiting ceased at once—all abdominal distension subsided, and the patient said he "felt like a new man." The sutures were now removed, the wound having closed except at the seat of the drainage-tube. In the line of two of the sutures, as I have stated, some suppuration had occurred and the little points continued to discharge matter for several days. Food was now given—first as milk, then as soup, etc. The bowels gave no farther trouble, and convalescence was rapid.

I think there can be little if any doubt that if the wound had been left as Dr. Anderson found it, the man would have died either from hemorrhage, peritonitis, or septicemia. The ligature saved him from the first danger, the sutures put in the gut averted the second, and the thorough cleansing of the cavity and the drainage-tube, prevented the third.

The sutures put in the bowel by the physician who first saw the case had failed of their purpose, and either opening still remained large enough to allow the escape of fecal and other matter into the peritoneal cavity. And few rules in surgery can now be considered as better established than that which declares that no wound, however minute, which opens a gut should be left unclosed. Professor Gross relates, in his monograph\* on Wounds of the Intestines, that in several of his experiments—on dogs—"death was produced, not from any undue injury inflicted on the bowel from stitching or any rough manipulation, but from the interval between the sutures being so great as to prevent the perfect closure of the wound; a fact," he very pertinently adds, "which should never be lost sight of in the management of a lesion of this kind." "I do not care, therefore," he continues, "how small the wound may be, if it is only a line and a half, or two lines, in extent, it should by all means be sewed up." In confirmation of this practice,

\*Nature and Treatment of Wounds of the Intestines. By Samuel D. Gross, M. D., Professor of Surgery, University of Louisville, 1843.



### *Knife-Wound of the Intestines.*

Dr. Gross quotes the following from Mr. Benjamin Bell: "However small a wound of the intestine may be, it ought always to be secured with a ligature; for although it is alleged by some that we should rather trust to nature for the cure of a small opening than to insert a ligature, to me it appears that the opinion is by no means well founded; insomuch that I would not leave even the smallest opening that could admit either feces or chyle to pass without stitching it up."

I have introduced the foregoing authorities in order that attention may be directed anew to the necessity for perfect closure of all wounds which penetrate the intestine—a fact which, as the case I have reported shows, is at least not always acted on; and that I may quote the following from the monograph of Dr. Gross referred to respecting the dilatation of the outer wound in order to facilitate the search for the injured bowel. Writing of wounds which penetrate or divide the gut and allow of the escape of feces, he says: "Here the most prompt and decisive measures must be resorted to, or the person will perish from peritoneal inflammation. . . . It will not do for the surgeon to fold his arms and look upon the scene as an idle and uninterested spectator. Far otherwise. He has a duty to perform, and that duty consists *in dilating the external wound, if it be not already sufficiently large, in hooking up the injured bowel, and in closing the solution of continuity with the requisite number of stitches, at the same time that the effused matter is carefully removed with tepid water and a soft sponge.*" The italics are my own. What Dr. Gross suggested, now more than forty years ago, as applicable to extensive wounds of the gut has, as is well known, recently been widened so as to embrace all penetrating injuries of the bowel, but the honor belonging to the entire procedure is now claimed by others.

I submit that it belongs to Dr. Gross.

LOUISVILLE, KY.

## EXTRACTUM PANCREATIS IN TYPHOID FEVER.

BY FRANK C. WILSON, M. D.

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In typhoid fever, more than in any other disease, do the indications point clearly and emphatically to the most careful dietetic management of the case from the beginning to the end of it. The debilitating effect of the continued fever, protracted through a period of four or six weeks and sometimes even longer, must be combated in every possible way, and yet without adding to the danger of loading the intestines with undigested food, of itself a source of evil and discomfort. Only that which is absorbed and assimilated is of real service to the system. In the enfeebled condition of the digestive organs very little of the food taken into the stomach can or will be digested, but passes down through the intestinal tract in a constantly fermenting state, thus adding to the discomfort by the increasing flatus, and over the inflamed and ulcerated Peyer's patches, producing possibly hemorrhage, or even death, by perforation. The great danger from this source has led some eminent physicians to advocate even total abstinence from food, confining the patient strictly to water, even for three or four weeks. If, however, food can be so thoroughly digested, before being taken into the stomach, that all will be readily absorbed and assimilated, leaving no residue, the indications will be fulfilled. Milk is the article of diet usually relied upon for feeding typhoid-fever patients, but even when the digestive organs are in a healthy condition it coagulates into a mass of curd as soon as it reaches the stomach. This hard mass has then to be digested and disintegrated before being absorbed. If this fails to be accomplished by reason of the small quantity or poor quality of the digestive fluids, the irritating mass passes down through the intestines, a constant source of annoyance and danger. This may all be obviated by digesting the milk with the pancreatic extract, as prepared by Fairchild Bros. & Foster, of New York. Milk so



treated can not be coagulated by even the strongest acids, its casein being transformed into peptone and in a condition to be at once absorbed and assimilated. There is noticeable a slight bitterness, to which the patient soon becomes accustomed, so that it is taken readily and produces no discomfort. Even this bitter taste may be avoided by stopping the process of digestion before it is entirely completed. It has been found by experiment that the objectionable taste is only developed when the casein is entirely peptonized. It is scarcely ever necessary to carry the artificial digestion quite so far, and when stopped at any point before completion the taste is perfectly natural. If immediately placed on ice, it can be kept as long as simple undigested milk. The ferment of the pancreatic extract is held in a latent condition, and when taken into the intestinal canal may still further aid in the completion of the digestive process.

To avoid the possibility of the patient becoming tired of the same article of diet day after day, its form of administration may be varied in a number of ways. As the casein is peptonized, and can not be coagulated by even the stronger acids, the milk so prepared can be utilized in making milk punch. This can be flavored with lemon-juice or any other acid desired. Thickened with gelatine, sweetened and flavored, it forms a delicious milk jelly suitable for convalescent patients and grateful to the taste.

During the past two years I have met with many instances in which the use of the pancreatic extract has yielded the most gratifying results. Not alone in typhoid fever is it useful, but in all instances where the digestion is enfeebled, or where it is interfered with by the presence of ulcerated or inflamed surfaces, the process of peptonizing the food will be found of service. In rectal alimentation its importance is manifest, the food so prepared being readily absorbed and appropriated without inconvenience or irritation. I have sustained patients with gastric ulcer entirely by nutrient enemata twelve or fourteen days. In this time the ulcer will be entirely healed so as to allow the cautious administration of peptonized milk in gradually increasing quantity, until a full meal can be taken.

To Dr. Roberts, who first suggested the importance of peptonizing the food, and to the Fairchild Bros., whose pancreatic extract enables us to so readily and thoroughly accomplish it, the profession owes an everlasting debt of gratitude, echoed by many patients whose lives have been saved by its use.

LOUISVILLE, KY.

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## REPORT OF A RARE FORM OF OBSTRUCTED LABOR.

BY JOHN A. OCTERLONY, A. M., M. D.

*Professor of Obstetrics and Diseases of Women and Children in the Medical Department of the University of Louisville.*

Mrs. J., aged forty-two, remarkably well developed and muscular. She had already given birth to eleven children. Her labors had always been short and easy, and she had ever been strong and healthy. Her last menstruation occurred in the latter part of April the preceding year. She was even certain as to the period of quickening. Her present pregnancy was rendered very uncomfortable, and at times painful, by great swelling of the lower extremities, which also soon became the seat of marked and extensive varicosities. Some weeks prior to the expected time of labor, she had a severe attack of general bronchitis of both lungs, from which she had just recovered when labor set in. During this illness, which confined her to bed for some time, there was not much improvement in the varicosity of the lower limbs. This was explained by the great impediment to the return of venous blood caused by the bronchial inflammation and the frequent and severe paroxysms of cough.

At midnight on the 22d of January past I was summoned to her house, and was told she was in labor. On my arrival, the os uteri was found very high up, and but slightly dilated, the amnion not yet ruptured, and the bag of waters just beginning to form. The pains were regular, but not expulsive.

The lower limbs were much swollen and varicose. The labia majora were a good deal larger than normal, and, owing to vari-

cosity, felt under the finger as if they contained bundles of large worms. In the course of two hours the os was found more dilated, and the bag of waters formed. The head presented in the left occipito-anterior position.

The pains had become strong and regular and quite frequent, but the head had made no progress. With each pain the labia became more and more turgid, and the veins of the vagina felt large and cordlike. The passages continued moist and free from heat. The mother's strength remained good.

At noon the bag of waters broke; the head was fully flexed, but rotation had not been completed. The labia had now increased so much that each was the size of my fist, and the canal of the vagina had been so much encroached upon that its caliber was much diminished. With each pain more blood was forced into these parts. The distension steadily augmented in spite of the support given by means of the hand holding a folded towel and steadily pressed against the labia during each pain.

The uterine contractions were still strong and regular. That the labor did not progress was evidently not due to failure of expulsive force but to obstruction to the passage of the fetal head, caused by the enormous varicose swelling of the vagina and vulva. At two o'clock P. M. the fetal heart was heard, quite distinct and regular, about 130, but the head had made but little progress and was still encircled by the fully dilated cervix. The mother's strength, however, began to flag, her spirits drooped, and the pulse became frequent and small. Further delay seemed dangerous. The veins, distended to the utmost, might at any moment give way in some place, and the risk of a thrombus would thus be incurred. That this is not trifling is shown by Blot, who found that out of nineteen cases five proved fatal, and that all the children of the mothers who died were still-born. Even if no obstruction had existed, the general condition of the patient was such as to demand immediate relief. The obstruction so encroached upon the vulva and vagina that it was with difficulty the hand could be passed up for the introduction of the blades of the forceps. Its application was somewhat diffi-

cult, but was at last accomplished. The blades entered the uterine cavity. I proceeded to extract slowly, making counter-pressure, at the same time causing counter-pressure to be made upon the varicose external parts. Delivery was completed without much trouble or loss of time. The child, a male, was not above the average size and was alive and in good condition. The placenta was delivered in a few moments. No injury occurred to the maternal parts. The enlargement of the labia and vagina rapidly subsided after the child had been born, and by the third day there was hardly any swelling left; in a week it had entirely disappeared. The mother made a good recovery and the child lived and did well.

Edema of the labia and vagina is occasionally so great as to impede labor, and this is generally mentioned by obstetric writers as one of the causes of dystocia. Thrombus of the vulva sometimes occurs, and may constitute an obstruction to the passage of the child. It does not, however, appear to be associated with marked varicosity, but to have been produced by the bursting of a vein under extreme blood-pressure during the pains. Such excessive varicosity as to constitute a formidable obstruction to the progress of labor must be quite rare. I can not recall any mention of such a case either by systematic writers or in periodical literature.

In the above case the woman would have sunk into powerless labor and exhaustion had she not been delivered by art. It is also probable that if the labor had been more protracted the child would have been born dead. The most imminent danger in such cases as this is probably thrombus. The treatment which I would adopt in a similar case would be, (1) To give steady support to the varicose parts by means of a properly folded towel pressed firmly against the labia both during and between the pains. This should be done in order to prevent further swelling and to guard against thrombus. (2) To deliver early with the forceps if the varicose enlargement appeared to offer marked obstruction to the progress of the fetal head.

LOUISVILLE, KY.

## Reviews.

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**A Practical Treatise on Materia Medica and Therapeutics.**

By ROBERTS BARTHOLOW, M. A., M. D., LL. D., Professor Materia Medica and General Therapeutics in the Jefferson College of Philadelphia, etc. Fifth edition, revised and enlarged. 1 vol., 8vo, pp. 738. New York: D. Appleton & Co.

This edition is larger than its predecessor by about one hundred pages, and has been adapted to the official standard of the last edition of the United States Pharmacopeia. In its present form it is one of the best text-books extant, and fully deserves the fullest meed of professional favor.

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**A Manual of Pathology.** By JOSEPH COATS, M. D., Pathologist to the Western Infirmary and the Sick Children's Hospital, Glasgow, Lecturer on Pathology in the Western Infirmary, Examiner in Pathology in the University of Glasgow, etc. 1 vol., 8vo, pp. 318. With three hundred and thirty-nine illustrations. Philadelphia: Henry C. Lea's Son & Co. 1883.

The author regards the aim of pathology to be the elucidation of the actual vital processes of disease. His object has been to give something more than pathological anatomy or general pathology. In order to do so, he considers etiology, anatomy, and general pathology together, in order to form a general conception of each morbid condition, and he expresses the belief that in so doing the subject gains in interest and intelligibility.

This is the most thorough and complete treatise on pathology of purely British origin. While limited time and space forbid an extensive analysis of the work, the perusal of it even in

a cursory manner must impress the reader with its excellence. Indeed it is a pleasure to be able to present its high claims to professional favor and patronage. The paper, printing, and binding are excellent, and combine to make an exterior worthy of the contents.

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**The Pathology, Diagnosis, and Treatment of Diseases of Women.** By GRAILY HEWITT, M. D., London, F. R. C. P., Professor of Midwifery and Diseases of Women, University College, and Obstetric Physician to the Hospital, etc. A new American from the fourth revised and enlarged London edition. With two hundred and thirty-six illustrations. Edited, with notes and additions, by HARRY MARION SIMS, M. D., Attending Surgeon to St. Elizabeth's Hospital, New York, etc., in two volumes. First volume, 469 pages; second volume, 561 pages.

Dr. Hewitt's work needs no introduction to the medical profession of America. It has been long and favorably known, and has had for a good many years a wide circulation in this country. It is, therefore, with satisfaction we welcome this fourth edition, the preface of which bears the date of hardly more than a year ago. This American edition has had the advantage of revision by Dr. Harry Sims, who is admirably qualified for this responsible task, which he has performed in a manner which must be most gratifying to the author, as it is creditable to himself, and his judicious and timely and not too numerous notes certainly add to the value of the book. Dr. Hewitt has furnished not only a treatise setting forth the present state of gynecology, but he also advances his own views on important topics in a clear, forcible, and thoroughly practical style. Birmingham & Co. offer this work at the very low figure of \$4.50. The typography is excellent, the volumes are neat and attractive.



## **Clinic of the Month.**

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**EXTROPHY OF THE BLADDER—GRANULATING FLAPS EMPLOYED TO COVER THE EXPOSED VESICAL SURFACE.**—Sir William MacCormac during his visit to Kentucky, in October last, did the first step of the operation now described, before the Medical Class at the University of Louisville, on a boy three years old, a patient at the University clinic. The following account of the entire procedure in such cases is taken from a paper contained in Volume X, 1879, of St. Thomas's Hospital Reports. After reporting a case in which the result was most satisfactory, the author says:

"With the object of covering the exposed vesical surface I made the incisions so that two flaps of skin and subcutaneous cellular tissue were raised from the subjacent aponeurosis in a bridge-like fashion, leaving each attached above and below for the purpose of blood-supply. One flap only should be made at a time, the second being mapped out and dissected up in a similar fashion when the first has thoroughly healed in its new position on the completion of the second step of the operation. In the course of three weeks the flaps become thick and vascular, and the under surface granulates. This must be kept separated from the granulating surface on the abdominal wall by strips of oiled lint interposed between.

"In slighter cases one flap may suffice, but usually two are needed. Each one should be cut as broad as the entire vertical depth of the exposed surface to be covered, and one third longer than the total width of the exposed mucous surface, in order to make a sufficient allowance for contraction. When the allotted interval has elapsed the flap is divided obliquely at its upper extremity, laid transversely across the exposed mucous membrane, and attached by a sufficient number of sutures at the

opposite side to a raw surface purposely prepared to receive it. This is done first with the flap on one side, and then, after a sufficient interval, with that on the other.

"In my patient I used the flap from the left side to cover the lower half, and made it in the following manner, the details mentioned being of importance: The internal incision should follow the inner margin of the displaced rectus muscle and run close to the edge of the exposed bladder, curving round its lower margin to the root of the penis. The external incision runs parallel to the first at the distance already mentioned. Great care is required in raising up the inner margins of the flaps lest the peritoneal cavity be opened, and any margin of skin remaining should be carefully removed. Care must also be taken not to open into the inguinal canal, which is often enlarged, and usually contains a hernial protrusion, or to expose the testes.

"The flap so raised contains every thing from the skin to the aponeurosis, and it is allowed to remain attached at each extremity by a broad bridge of skin. There is thus no risk to its vitality, and by the time the second stage of the operation is reached it has doubled or trebled in thickness, so that after three weeks the flap will have become so thick and vascular that there is no tendency to slough whatever after its partial separation. It may now be safely severed at its upper extremity obliquely from within upward and outward, as indicated by the dotted line, and then laid transversely across the lower part of the exposed bladder, and sutured to the opposite margin after paring the edges of contact. The lower two thirds of the vesical mucous membrane were now covered in this way. This flap I also united at once to the glans penis, whose upper margin was split open for the purpose of receiving it; but in some cases it is better to make a roof for the urethra by transposing the foreskin from below as a species of bridge across the urethral groove, and uniting the upper margin of this to the lower border of the flap at a later period, or a urethra may be formed by a special operation for the purpose.



"As soon as any fistulæ which may remain are closed the next stage of the operation may be proceeded with, which consists in utilizing the flap from the opposite side to close in the upper part of the bladder. This is made in a similar way to the first, only that the inner extremity terminates at the upper point of attachment of the first flap; and at the same time the skin should be raised in the median line carefully for a distance of three quarters of an inch along the upper margin of the bladder.

"After a similar interval of three weeks has elapsed this second flap is cut obliquely at its upper end and turned across the upper part of the bladder. The adjacent margins of the two flaps are then pared and united together by sutures, while the upper margin, also pared, is united to the pared edge of the central small flap of skin, which has become thick and vascular in the interval. In this way the whole of the bladder surface will be recovered and protected.

"Professor Thiersch allows a year as the period needed for the completion of the various steps of his method of operating.

"By means of a pad pressing upon the meatus a certain quantity of urine can be retained, and by degrees the flaps of skin will yield somewhat so as even to permit a certain quantity of urine to accumulate.

"An operation of this kind appears to me obviously preferable to any of those where the skin surface is turned toward the bladder; no known means completely prevents the hair-growth, and on each hair phosphatic deposits take place.

"That healthy urine does not appear to interfere injuriously with the healing process was very evident after most of the operations performed on this boy, the edges united by first intention as easily as in a wound of the face; and we see the same after operations for vesico-vaginal fistula, as, in a word, urine has no prejudicial influence whatever on granulating surfaces.

"The employment of granulating flaps is of great importance in various plastic operations, and in none does it seem more likely to prove useful than for remedying such a defect as extroversion of the bladder."

A NEW OPERATION FOR THE REDUCTION OF CHRONIC INVERSION OF THE UTERUS.—B. Bernard Browne, M. D., writes, in the *New York Medical Journal*, as follows: After devoting a considerable amount of time to the study of the different methods of replacing a complete inversion of the uterus of long standing, and appreciating the difficulties and dangers attending the operations already devised, I concluded to adopt a new procedure in a case which resisted many of the methods referred to. The simplicity of the operation, and the ease and success with which it was performed, led me to suggest it as one to be considered in all difficult cases. The problem to be solved is, how to get the fundus back through the rigid and constricted cervix.

The injuries which frequently result from prolonged taxis, such as rupture of the vagina, rupture of the uterus, peritonitis etc., are well known. Repeated failures at reduction have occurred to the most skillful operators. Up to this time Thomas's method, which consists in abdominal section over the cervical ring and dilatation from above, has been the only one that could be said to be absolutely sure of accomplishing the replacement in cases which had resisted the other plans—such as the rapid reduction by taxis; Noeggerath's method of indenting one horn of the uterus and reinverting it first; Courty's method of passing two fingers into the rectum and dipping them into the cervical ring, with counter-pressure upon the fundus; Emmet's plan of receiving the fundus in the palm of the hand and spreading the fingers out in the vagina, with counter-pressure from above; or the very excellent and successful method of Dr. I. H. Tate, of Cincinnati, which consists in holding the cervical end of the uterus firmly between two fingers in the rectum and one in the bladder, while the thumbs press upon the fundal extremity.

The patient upon whom I operated presented the following history: Mrs. I., aged twenty-eight, white, married ten years, has had two children, the youngest six years of age, and has had no miscarriage since. She is a large, stout woman, with thick abdominal walls, weighs about two hundred pounds, and

has all the appearance of perfect health. Three months after her last confinement she had a severe hemorrhage from the vagina upon rising in the morning. She laid at the point of death for nine weeks, and since then has been unable to be out of bed for more than two or three weeks at a time, suffering at intervals with hemorrhages, which have lasted from two to four weeks. She has had to be extremely careful in her movements at all times, for fear of bringing on a hemorrhage. Her attending physician had made the diagnosis of "bleeding tumor of the uterus," and offered from time to time to remove it, which, fortunately, was not done. In March, 1883, she came under my care, and was examined under an anesthetic. The diagnosis of chronic inversion of the uterus was made. A prolonged effort at reduction by taxis did not succeed in restoring the uterus, but a profuse hemorrhage was excited by the manipulations, and the vagina had to be tamponed with cotton saturated with dilute Monsel's solution. A short time afterward another ineffectual effort at reduction was made. Then continued pressure with Gariel's air-pessary was resorted to, and used for six weeks, followed at the end of that time by another ineffectual effort at reduction by taxis. In October she came into the Woman's and Child's Hospital, where I made another attempt at reduction, trying Noeggerath's and Courty's methods, but again with failure. The os could be plainly felt through the rectum, but the cervix was so firm and unyielding that it could not be made to dilate.

On November 2d, the bowels and bladder having been evacuated, she was placed under ether, the inverted fundus was drawn outside the vulva with a strong vulsella forceps, the openings of both fallopian tubes were brought plainly into view, and an incision one inch and a half in length was made through the posterior portion of the uterus (avoiding the fallopian tubes and larger vessels at the sides of the uterus). Through this incision Sims's large dilator was passed up into the cervix and expanded to the fullest extent; the rigid tissues of the cervix were felt to relax; then, upon withdrawing this dilator, Nos. 2 and 3 of

Hanks's hard-rubber dilators (three fourths and one inch in diameter) were passed through the cervix. The finger was also passed to feel that there were no adhesions. The incision in the uterus was then sewed up with carbolized silk-worm gut, and, with slight manipulation, the fundus was easily replaced through the now passable constriction.

The whole operation was performed in less than thirty minutes. There was considerable hemorrhage from the uterine cavity when the uterus was first replaced. On the next day the temperature was  $102^{\circ}$  Fahr., but gradually returned to the normal condition, which it reached on the fourth day. During the first week she complained of severe pain in the uterus, but this was controlled by full doses of opium. She was placed upon the table and examined on the 14th (twelve days after the operation). The cervix was somewhat patulous, but, with this exception, the parts were all in a normal condition.

*Conclusions:* (1) This operation is not proposed to supersede ordinary taxis in the reduction of chronic inversion of the uterus. (2) It is not more dangerous, but much more certain, than prolonged or rapid taxis. (3) We avoid the danger of bruising the tissues and rupturing the vagina. (4) As an operation for inversion, it is less dangerous than laparotomy. (5) Unless there be adhesions (which rarely exist), we can always feel certain of reducing the inversion at one operation.

OPHTHALMOLOGICAL METHODS IN PARIS.—The Paris correspondent of the *Orvosi Hetilap* writes that the most eminent representatives of ophthalmological science in the French capital are foreigners of German, Polish, or Greek extraction. Among these he considers Dr. Meyer to be rather conservative. Dr. Gabrowski, who has the largest *clientèle*, is very fond of abstractions of blood. He orders leeches freely in different forms of conjunctivitis. He treats phlyctenular ulcers of the cornea by instillations of pilocarpin. For cataract he employs the old flap operation, without iridectomy, having entirely discarded Von Graefe's method. He uses the latter's knife, however, and

makes the flap upward. He has made a series of about ninety of these flap operations, but has not yet published the results. De Wecker performs keratotomy for *ulcus corneæ serpens*, and follows up the incision by instillations of eserine. For the latter he substitutes atropine if there is a recurrence of hypopyon. For superficial abrasions of the cornea he also orders a solution of pilocarpin to be dropped into the eye. In cases of serous iritis, he avoids atropia and employs subcutaneous injections of the alkaloid of *jaborandi*. The number of patients at his clinique is smaller than at Gabrowski's, but his operative material is greater. He extracts cataracts by his well-known modification of Von Graefe's method. He uses antiseptic precautions. After performing tenotomy for strabismus, he closes the conjunctival wound by a suture applied in such a way as to approximate the angles of the wound and not the sides. He claims that by this suture the sinking of the caruncle is effectually prevented. He prefers sclerotomy to iridectomy for glaucoma. If the disease returns in an eye which has been already operated upon, he incises the scar. This operation he terms *cicatriscotomy*. He still continues his experiments of forcibly stretching the optic nerve in case of atrophy. The most peculiar notion of De Wecker is certainly his substitute for the protective bandage in cases of corneal ulcer. It consists in an apparatus made of glass and shaped somewhat like an artificial eye. This being introduced behind the lids allows the patient to see, at the same time that it protects his cornea from the air and the contact of the lids.

REPORT OF A CASE OF DISCHARGE OF BILE THROUGH THE UMBILICAL CORD IN A NEW-BORN BABE.—W. B. Brooks, M. D., Fort Worth, Tex., writes, in the *Courier-Record of Medicine*: I delivered Mrs. S. of an apparently healthy male child, ligated the umbilical cord as usual, and no abnormal appearance being noticed at the time. Upon the fourth day, at my customary visit to the mother, the nurse called my attention to the child, stating that "there was something wrong with its navel." On

examination, I found that the ligature had cut through the cord and come away, leaving about an inch and a quarter remaining attached to the abdomen. This remaining portion of cord had a vascular, fleshy appearance, standing out almost at right angles from the body, with a small hole in the center, from which was discharging a greenish fluid, which appeared and afterward from chemical tests proved to be bile. I again ligated the cord about one-half inch from its extremity. Two days afterward I found the ligature had again cut through, and the umbilical cord discharging bile as before. The third ligature was then placed around the cord one half inch from its extremity, as before, and the precaution taken to barely tie it tight enough to stop the flow of bile. But, in spite of this precaution, the ligature again came away within two days, leaving the stump of cord discharging bile as before, though each time the flow was very much lessened in quantity. Having failed three times in stopping the biliary fistula by the ordinary ligature thrown around the cord, and seeing that it was getting so short that, should it fail one more time, I would not have sufficient cord to ligate, I took the precaution to arm a large needle with a very coarse thread double, and, passing it directly through this stump close to the abdomen, proceeded to ligate in the ordinary method used for hemorrhoidal tumors. This time the operation proved successful, and in a few days the child was sound and well. The case is of interest only from the fact of its rare occurrence, the writer of this article having been able to find only one other case upon record. Several other physicians of the city were called in to see the child at the time.

**RUPTURE OF HEART IN TETANUS.**—Dr. Ferguson recently presented to the New York Pathological Society a specimen of rupture of the heart in tetanus. A male, forty years of age, married, a native of Ireland, and a glazier by occupation. On September 7th last, he sustained an injury to his left hand, tearing away the soft parts from its dorsal aspect and exposing the extensor tendons. His injury was dressed antiseptically, and



for three weeks he did well; at the end of that time, however, he experienced stiffness and rigidity of the muscles of the face and neck, giving rise to retraction of the head; soon after he was seized with convulsions, which became more frequent and more severe in character until October 13th, when, during a convulsion, he suddenly died. He had opisthotonos during his convulsions, and suffered greatly from dyspnea. He was in the hospital only five days, and during that time he could not separate his jaws more than one fourth of an inch. His pulse was full, strong, and regular, varying from eighty to ninety beats a minute. His temperature ranged from  $99^{\circ}$  to  $101.6^{\circ}$  F., and his respiration forty to fifty a minute. He was treated with fluid extract of physostigma. On autopsy the brain and cord were found intensely congested. The organs in the abdominal cavity were normal. The lungs were congested and edematous. The pericardium contained one hundred cubic centimeters of pure blood. The cavities of the heart were dilated. The ventricular walls were thin, and the muscular tissue was brownish. The valves were competent; there were a few small patches of atheroma in the segments of the mitral valve. In the anterior border of the heart, one inch to the right of the apex, was a circular opening which admitted a probe one eighth of an inch in diameter. The right ventricular wall surrounding this opening was about a line in thickness. The muscle-cells of the heart were normal.

GASTROSTOMY.—In the *London Letter of the Canada Medical and Surgical Journal* for November are given the particulars of a case, in which the operation was performed by Mr. Pepper, of St. Mary's Hospital. The patient, a woman aged sixty, had had symptoms of obstruction of the esophagus for some months, but of late this had become so complete that no bougie, however small, could be made to pass. She was much emaciated, but had not a cachectic appearance, although a diagnosis of malignant disease had been made.

The operation was divided into two stages: the first consisted in making a straight incision from the point of the xiphoid car-

tilage downward and slightly to the left for a distance of about two and a half inches. The aponeurosis muscles having been divided upon a director, and all bleeding arrested, the peritoneum was opened and the stomach sought for. The left lobe of the liver was seen first to present in the wound, but soon the stomach was recognized and drawn forward. Neither the omentum nor transverse colon interfered with the finding of the stomach, as they sometimes do. The stomach was then stitched all around to the edges of the wound and peritoneum, care being taken to pass the needle through the peritoneal and muscular coats. The kind of suture used throughout was carbolized silk. The operation was performed under the strictest antiseptic precautions, a heavy spray of one to forty carbolic acid being used throughout. The wound was dressed with carbonized gauze. The patient was sustained with nutritive enemata, and progressed without a single bad symptom.

On the eighth day a small opening that would admit a number twelve catheter was made into the stomach, and when the patient was last heard of she was still doing well.

ON THE USE OF WARBURG'S TINCTURE IN MIASMATIC FEVER.—In a letter to the Medical Record, Dr. John T. Metcalf gives his experience with this remedy: For many years he has been accustomed to prescribe Warburg's tincture in the treatment of miasmatic fever which would not yield to quinia. Half an ounce of the tincture, given on an empty stomach, early in the morning, is the dose which was rapidly and completely successful in its effects. The taste being very bitter and nauseating, he has caused the tincture to be evaporated in a vapor bath to such consistence as would allow it to be put into gelatine capsules. This has answered the desired end perfectly without causing discomfort of any kind. When the tincture has been evaporated to the requisite degree, a capsule will contain the potency of two drams of the tincture.

With some persons rather too active purgation follows the ordinary dose of two capsules. This can be easily regulated by



leaving out or diminishing the amount of aloes in the original formula. Excellent results also follow the administration of the capsules made by evaporating the modified tincture in which the other alkaloids of cinchona are substituted for the sulphate of quinine.

In cases of intermittent fever, which tend to recur after having been once broken, he relies much more upon the daily dose of two capsules, taken early in the morning, than on any other remedy known.

The evaporated mass becomes hard very soon unless glycerine be mixed with it before filling the gelatine cups.

CELLULOSE AS A DRESSING FOR WOUNDS.—Dr. Fischer, of Trieste, proposes the employment of cellulose as a dressing for wounds. Before it is applied, the cellulose is impregnated with water or some medicated solution; it is then covered with an impermeable substance, such as rubber cloth. This method of dressing is particularly applicable to wounds the cicatrization of which is favored by moist heat.

Fischer claims the following advantages for this method: (1) On account of its perfect purity it is preventive of septic conditions. (2) It is extremely light, and will have none of the bad effects sometimes occurring with heavy dressings. (3) It causes neither erythema nor erysipelas in the vicinity of the wound. (4) The heat and humidity are preserved for twenty-four hours or more. (5) It does not adhere to granulating surfaces. (6) It can be perfectly adapted to any surface upon which it is desired to apply it. (7) It is cheaper than other substances used for dressing wounds. (*Journal de Médecine de Paris.*)

TETANUS FOLLOWING MISCARRIAGE.—Dr. John Neff reports a case to the Baltimore Medical Association: The patient, who was an Irish woman, aged thirty-eight to forty years, and a hard drinker, was three months advanced in her pregnancy. She got along well after the miscarriage, and came down stairs on the second day. On the ninth day she went out in the yard,

the weather being rather cold. On the tenth day she complained of stiffness of the jaws, followed by a similar condition of the cervical and spinal muscles and tetanic convulsions. Death took place on the thirteenth day after miscarriage. The treatment embraced cannabis indica, bromide of potash, and chloral, and hypodermic injections of morphia; the last seemed to give more relief than any thing else. Her mind was clear up to just before the end. There was no apparent cause for the tetanus, no retained placenta or membranes. (Maryland Medical Journal.)

**GANGRENE OF THE PENIS AS A CONSEQUENCE OF ACUTE GONORRHEA.**—Jeszenszky reports the case of a robust countryman, twenty-three years of age, who was seen by him seven days after infection: the discharge and swelling of the penis had then lasted four days. The glans was completely covered by the swollen prepuce; there was a profuse greenish discharge and sharp pain at the root of the penis, which was greatly swollen and of a greenish brown color. Incisions were made in both sides of the penis, extending along its entire length, and a large quantity of fetid pus evacuated. On the next day several vesicles had formed on the external skin surface, and a circular line of demarkation was commencing to form at the inner end of the incisions, and three days later the entire gangrenous skin separated; no fever was present. Healing took place by granulation under iodoform dressings, and was complete in about five weeks, leaving two broad scars on the upper surface of the organ. (Medical Times.)

**TYPHOID FEVER AND PREGNANCY.**—Dr. Martinet thus concludes a paper in *L'Union Medicne*: (1) Typhoid fever is rare in pregnant women. (2) It determines abortion in about one half of the cases; the more surely, the less advanced is the pregnancy. (3) The lightest forms may produce abortion. (4) This complication arises usually in the course of the third week, and sometimes at the beginning of convalescence; it

causes no recrudescence nor return of fever. (5) Puerperal accidents are the exception. (6) The immediate causes of abortion are unknown; elevated temperature, active or passive, uterine congestion, and changes in the blood, although seemingly the most probable, can not be regarded as the causes in all cases. (7) The treatment for the fever and the miscarriage is the same as for each condition alone.

**ANEURISM OF THE SPLENIC ARTERY.**—Dr. Davidson showed the spleen from a woman, aged fifty-five, who had died of epithelioma of the esophagus, in which the splenic artery showed four or five small saculated aneurisms. The coats of the vessel appeared perfectly healthy, and, excepting some atheroma about the arch of the aorta, the circulatory system was normal. The little aneurisms were all situated at the bifurcations of the vessel, and the spleen showed two large infarcts; so that Dr. Davidson was of opinion that an embolus had been carried into the splenic artery and rested a while at its first division, and that it had been broken up, parts of it resting again at other divisions, and being ultimately carried on into the spleen. He thought that where the embolism has rested, the arterial coats might have become softened, and subsequently dilated, thus explaining the position of the aneurisms.

**THE VALUE OF POST-LARYNGEAL PAPILLOMATA AS A MEANS OF DIAGNOSIS IN TUBERCULAR DISEASE.**—Dr. Major discussed two varieties of these—the velvety, and the filamentous or feathery, being probably two degrees of the same disease. The author related several cases in which, from these growths, he had diagnosed tubercular disease. In the discussion that followed, Dr. Asch said he had often seen this peculiar appearance in the larynx in cases of tuberculosis, but did not regard it as absolutely diagnostic, as he had seen it occur in other cases as well. The author agreed that where the velvety appearance existed there was not necessarily actual pulmonary complication, but he had always found tubercular tendency and tuberculosis

in the family. As far as he had observed, after the filamentous growths had appeared, recovery had not taken place. (London Medical Record.)

**HERNIARIA GLABRA**, besides being of benefit in acute cystitis of the neck of the bladder, has been used successfully in chronic cystitis and in the bladder and urethral troubles attendant upon certain conditions of the womb and vagina. It seems also to possess an important preventive action in cases of gonorrhea, as it limits the inflammation to the anterior portion of the urethra and renders less liable the extension of the disease to the deeper part of the urethral canal, its adjuncts and the bladder. It has been used by one physician in thirty cases of gonorrhea, and in none of these cases has the inflammatory action passed deeper than is ordinarily found in a simple case of this disease. This preventive action will, as a matter of course, render far less probable that disagreeable but common accompaniment of gonorrhea, epididymitis. (Cincinnati Lancet and Clinic.)

**TANNATE OF SODIUM IN CHRONIC NEPHRITIS.**—Lewin first recommended tannate of sodium in nephritis, and Ribbert's experimental researches demonstrated its action in causing decreased elimination of albumen.

Briese has used it, in four cases in Mosler's clinic, prepared as follows: Solution of tannic acid, two parts to one hundred; add solution of bicarbonate of soda (nine to five) ad react. alcalin. Dose, one tablespoonful every half hour. This mixture was not equally well taken by the patients. In some cases it caused gastric disturbances and vomiting. The daily quantity of albumen eliminated by the urine was not diminished, the nephritis went on, and the patients grew worse daily, and it was apparent that the remedy was, in these cases at least, of no value whatever. (*Centralbl. f. Klinisch. Med.*)

**RELIEF OF FETID SWEATING FEET BY SUBNITRATE OF BISMUTH.**—M. Vieusse (*Gazette Hebdomadaire*) recommends highly

the use of this drug in this affection. The fetid sweat follows different forms of affections of the feet, sometimes the derm is naked and exposed from the maceration of the epidermis, and is the seat of severe pain. At others the skin does not seem to be altered at all, while the odor from the sweat is very marked. In either form frictions, with subnitrate of bismuth, have been followed with success, by using twenty or thirty grams of the drug, being careful to rub it well into the interdigital spaces. In most cases its daily use for fifteen days produces perfect relief. The epidermis becomes firmer and loses its whitish appearance, is less wrinkled and adheres to the subjacent tissue. The secretion diminishes.

**ETHER IN THE TREATMENT OF SORE THROAT.**—Professor Contalo employs an ether spray in the treatment of pharyngitis. The applications are made several times a day, according to the gravity of the case. Under their influence, it is claimed, the temperature falls, the vessels contract, and the local condition is speedily improved. In two cases a fibrinous exudation was detached and not reproduced. Ether, according to the author, deserves a trial in pharyngeal diphtheria, not only as an antiseptic agent, but also because the pain is thereby greatly diminished, and the taking of nourishment facilitated. Two cases of pseudo-membranous pharyngitis were successfully treated by this method. He insists especially upon the rapid lowering of temperature following the applications of ether spray. (Medical Record.)

**ALTERATION IN THE SECRETION OF MILK UNDER THE INFLUENCE OF DRUGS.**—According to Stumpf, when iodide of potassium was administered to goats, the yield of milk was reduced, while the percentage of fat and sugar was raised; salts and albuminoids were unaltered; the reaction became alkaline. Small doses of acetate of lead produced no change of composition in the milk, nor altered the yield; the same negative results were obtained with morphine. Pilocarpin at first only

reduced the sugar. Salicylate of sodium considerably raised the yield. Alcohol did not alter the yield, but the solids increased, while the specific gravity increased. When beer was given, the specific gravity fell, but the fat rose in quantity, as did also the sugar. (*Journ. Chem. Soc. fr. Biederm Central.*)

**REMOVAL OF A PIECE OF STEEL FROM THE VITREOUS BODY BY THE ELECTRO-MAGNET.**—Mr. Snell related the particulars of this case, and introduced the patient, a young man, who, while striking a wedge in a coal-pit, had been hit with a splinter in the left eye. The accident occurred three weeks before he came to the Sheffield Infirmary. A piece of steel was discovered with the ophthalmoscope moving about in the vitreous body; it had passed through the cornea at its lower margin, and had also penetrated the lens, of which there was a slight opacity. It was immediately removed through a sclerotic wound by means of the electro-magnet needle. At the time of exhibition of the patient, twelve days after the operation, the eye was quiet; the vision was =  $\frac{1}{16}$ ; the fragment weighed .0046 of a grain.

**DELUSIONS AND EXECUTIVE ABILITY.**—The Birmingham Medical Review reports that one of the members of the Executive Council of the Bank of Brussels was many years ago attacked by the delusion that his legs were glass, and positively refused to move. A financial crisis came, involving the bank to some extent. Mr. B. got up and went to Brussels, where by his energy and skill he largely assisted in getting matters straight. At the end of the month he returned home, remarked how marvelous it was that he had not smashed even one of his legs, and, taking to bed, never again left it. In all lunatic asylums patients combining business ability with the most remarkably fixed insane delusions are to be found.

**URINARY CHANGES DIAGNOSTIC OF GASTRIC DISEASE.**—Mr. Rommelaire, in the *Jour. de Med. de Bruxelles* for September, says: A cancerous ulceration of the stomach is attended with



diminution in the amount of urea excreted per diem, and also of the urinary chlorides. Simple gastric ulcer is associated with normal azoturia, if that expression be allowed, or even hyperazoturia, and the chlorides are of normal amount or in excess. Spreading gastric ulcer is accompanied by normal or hyperazoturia, but with decrease in the chlorides of the urine. If these observations are verified, they will constitute most important diagnostic factors.

**TAIT'S OPERATION—RECOVERY.**—Dr. W. T. Lusk presented specimens and related the following to the New York Obstetrical Society: The patient was sent to the hospital by Dr. Buchanan Burr, with the message that hers was "a good case for Tait's operation." She was twenty-four years of age, had been married four years, was sterile, had previously always been well, and had menstruated regularly and without pain. Within a year past she had begun to suffer from paroxysmal pains, commencing on the left side of the pelvis and extending upward across the abdomen and down the left leg. The pains were excessively severe, came on suddenly, lasted for several hours, and then entirely disappeared; the patient would feel that she was entirely well, when another paroxysm would occur before the lapse of twenty-four hours; they usually came on at night. Dr. Lusk, on examining her, found a tumor extending across the left half of the pelvis, and having its origin behind the uterus. There seemed to be obscure fluctuation; the consistence of the tumor enabled him to exclude fibroids; the absence of tenderness made it almost absolutely certain that it was not the result of pelvic cellulitis. The diagnosis then lay between a dilated fallopian tube and a small ovarian cyst. The fact that the tumor was firmly adherent rendered ovarian cyst doubtful; in that case adhesions rarely formed while the cyst was small. On the other hand, it seemed impossible that the fallopian tube could have attained to the apparent dimensions of the tumor. The patient was kept in the hospital a month to make sure that the pains were not hysterical, and that the tumor was not dimin-

ishing. As no relief was afforded, however, the patient was informed of the risks of an operation, and of the possibility of failure to produce relief. She concluded to have it done. An incision two inches and a half in length was made, the finger introduced, and the tumor recognized to be a dilated fallopian tube. The extremity lay directly behind the uterus, and was firmly adherent to that organ. The entire tube, thus bent upon itself, filled the left side of the pelvis, and was, throughout its entire extent, adherent to the pelvic floor. The adhesions were separated with difficulty with the fingers. It was necessary to increase the abdominal opening to four inches in length before the tumor could be withdrawn. The appearance was very much like that of large intestine, and its true nature was determined beyond doubt only after careful inspection. Sponges were packed into the cavity where the tumor had lain to absorb the slight amount of oozing which was taking place. A ligature was applied around the pedicle, and the tube removed. All bleeding had ceased when the abdominal wound was closed. The patient made an excellent recovery, no untoward symptom having developed; pain had since entirely disappeared. The origin of the trouble in the first place could not be explained; the patient had previously been healthy, had never suffered from pelvic peritonitis nor cellulitis, nor had she had venereal disease. There was said to be consumption in the family. The diseased tube contained pus; the other healthy and not interfered with.

ON THE DIFFERENT MYDRIATICS.—John Tweedy, F. R. C. S., writes, in the *Practitioner* for November, that there is no specific difference between atropine or eserine and the other mydriatics or myotics. Some are stronger than others; duboisine, for example, is stronger than atropine, which in its turn is stronger than homatropine; and eserine is stronger than pilocarpin.

The recognition and appreciation of these different effects of mydriatics and myotics in different states of the eyeball is of such clinical importance that it may be well to embody them in a series of therapeutical maxims. There are already some

maxims generally accepted by ophthalmic surgeons. For instance, *In iritide, collyria stimulantia plus damni quam commodi ferunt*, is a very old one; and there are few practitioners now who are not fully alive to drawbacks to solutions of lead as eye lotions. There is another, a drug in common use even among ophthalmic surgeons, which, in my opinion, is much more objectionable than lead lotion. While lead lotion is apt to produce opacities on the cornea from depositions on abraded or ulcerated surfaces, alum, from its solvent action on the corneal cement, frequently gives rise to perforation of the cornea whenever the epithelium is removed by injury or inflammation.

It should, I hold, also be a maxim not to use atropine when the anterior chamber is shallow unless there be unequivocal iritis. A shallow chamber with a semi-dilated pupil and slight increase of hardness absolutely contra-indicates atropine. Atropine applied to a glaucomatous eye may induce rapid and more or less permanent blindness, whereas eserine may, as a rule, be relied on to give temporary relief, if not occasionally to effect a permanent cure. Again, atropine is essential to the cure of iritis, but eserine would not only aggravate the symptoms but imperil the sight. It becomes, therefore, a matter of as much importance to decide when to abstain from atropine or eserine as when to have recourse to it. Now this is sometimes a matter of very great perplexity and difficulty, only to be safely settled by a critical and methodical analysis of the various symptoms, both objective and subjective, followed by synthetic re-grouping. Cases of inflammation of the eye, accompanied with increased hardness of the globe, are not uncommon, in which it is difficult to decide off-hand whether the character of the inflammation is glaucomatous or iritic. No difficulty need arise when the inflammation is not accompanied with increased hardness. Increased hardness is always present during an attack of glaucoma, but is only occasionally a concomitant of ordinary iritis or of aquo-capsulitis.

In glaucoma eserine is indicated; in iritis, atropine; and in aquo-capsulitis, if any thing, weak solutions of atropine.

TREATMENT OF THE PLACENTA AFTER THE BIRTH OF THE CHILD.—Prof. Dohrn sums up the comparative results to the woman, in cases in which the placenta was left to nature, spontaneously expelled, or treated by Credé's method:

1. In one thousand lying-in women in whom the expulsion of the placenta was left to nature, the results were far better than in one thousand others in whom Credé's method of expulsion was used.

2. The one thousand lying-in women in whom the placenta was spontaneously expelled had considerably less hemorrhage and fever after delivery. In those cases treated by Credé's method, portions of the membranes were frequently retained, and there were more fatal cases than in the others.

3. The disadvantages which are conditional to the method of Credé, are especially seen in the cases in which the placenta is expressed during the first five minutes. After a longer time the expression was more complete, but never as safe as by the spontaneous method. (*Deutsche Med. Wochensch.*)

LACERATION OF VAGINA AND PROFUSE HEMORRHAGE IN FIRST COITUS.—Dr. Mundé was called to see a girl, aged twenty-two (*American Journal of Obstetrics*), pallid and anemic from loss of blood. She had been married the day before, and there had been but one connection. It was not attended by severe pain nor immediate hemorrhage, but some hours after she observed bleeding from the vagina, and sent for a physician, who gave ergot, but without benefit. Another physician put ice into the vagina. Dr. Mundé then examined the hymen, or the source of the bleeding, but it came from higher up. Introducing a Sims's speculum, the vagina was seen to be ruptured on the left side for about two and a half inches, extending from one inch above the introitus up into the right fornix. The uterus was retroverted. He assumed that there was disproportion between the male and female organs. The bleeding was checked by firm tamponade with cotton disks. When the patient was seen a week later the wound was partly healed. Two years ago he

attended a case of rupture of the hymen up into the vagina along the urethra, during first coition, in which tamponade was required to check profuse hemorrhage.

**LUMBRICUS IN THE LIVER.**—Dr. Oks, of Rasgrad, Bulgaria, describes in *Vratsch* the case of an almost moribund phthisical patient, who was seized with vomiting and icterus. The liver was much enlarged. After death, the usual appearances of advanced phthisis were discovered. All the biliary ducts were dilated, and the common duct was occupied by a large female lumbricus; one extremity of its body hung free into the duodenum. Deep in the substance of the liver a smaller male lumbricus was found, impacted in a biliary duct. This is a rare, but not entirely unknown, complication of a parasitic disease. (British Medical Journal.)

**PAINLESS TREATMENT OF CONDYLOMATA.**—Nossbaum (*Münch ärztl. Intell' bl.*, 1882,) recommends the treatment of small condylomatous patches on the penis by daily washings with salt solution followed by the sprinkling over them of calomel powder. Chemical change takes place and corrosive sublimate is produced; the condylomata disappear, and no pain felt. Solution of corrosive sublimate in collodion, which acts more quickly, gives rise to much pain, and requires the patient to rest in bed. The proposed method is old, and has fallen into unmerited disuse.

**SUBPERITONEAL INJECTIONS OF ALBUMINATE OF IRON IN CHRONIC ANEMIA.**—Prof. A. Vachetta, having noticed the results obtained with this preparation when administered in the ordinary way, has endeavored to ascertain whether the peritoneum would not absorb it better in larger quantities and more quickly than the mucous membrane of the stomach. From experiments on dogs, he concludes that the effects of albuminate of iron are more readily obtained by subperitoneal administration than by any other method, and that no inconveniences result from this mode of administration. (*Gazz. degli Ospitali.*)

**CASE OF MYXEDEMA.**—Elizabeth M. Cushier, M. D. (Archives of Medicine), writes: Female, aged fifty-seven. Her general health had fallen off since nervous shocks in 1861. Within a few years after that time, swelling of the face was noticed, inactivity, slight deafness. When first seen by author (1877), the legs were edematous, the tissues of the face thickened, the eyelids baggy, suggesting Bright's disease, but there was no albuminuria. She improved under tonics and diuretics.

After two years there was a return of the edema in the legs, vesicles formed and became inflamed and ulcerated; the walk was slow and clumsy; she was slow in rising from the chair and lifting her head. No anesthesia. The face gradually became more characteristic; the aspect expressionless, the cheeks firm, waxy, rosy pink in color; the skin round mouth and eyes white and transparent; the lips motionless. Temperature subnormal, pulse slow. Subsequently the cardiac dullness became much increased in area; the abdomen swelled. She died in June, 1882, after an attack of facial dermatitis and inflammation of the left upper arm.

*Post-mortem.* The subcutaneous tissue of the neck seemed infiltrated with transparent material; the heart was hypertrophied, the kidneys rather large. In all these organs there was seen, microscopically, a swollen state of the connective tissue and an infiltration with small, spherical, highly refractive bodies. The normal histological elements were atrophied. In the thyroid, which was small and undergoing (in the left lobe) cystic degeneration, it was found that the alveoli were filled with hyaline material and the blood-vessels were infiltrated. The changes in the spinal cord were as follows:

*Vessels.* Their walls were thickened and infiltrated with hyaline substance; the vessels themselves were dilated, and there were numerous small hemorrhages, many of them old.

*Nerve-cells.* These had undergone yellow degeneration, or were atrophied, or had lost their processes. These changes were most marked in the lumbar region; they affected both the anterior and posterior cornua.



*White substance* showed small spaces filled with hyaline material; here and there the nerve-fibers were atrophied.

The author remarks on the limitation of the mucoid edema to the skin of the face and neck, and upon the paresis of the lower extremities. This latter she explains by the lesions in the lumbar cord. The identity of the pathological process in the cord and in the other tissues seems to show that they are not related as cause and effect, but form parts of some general disturbance of nutrition.

RECOVERY AFTER A LARGE DOSE OF DIGITALIS.—Dr. Antonin Martin reports, in *L'Union Médicale* for September 18, 1883, the case of a man, forty years of age, who had taken through mistake an infusion containing six hundred grains of digitalis leaves. He was not seen until twenty-two hours after the accident, at which time he was vomiting incessantly, the skin was cold and dry, the extremities were cold, and he complained of pains in the legs; there was no headache, the pulse was slow, twenty-five to the minute, strong and regular. Two days after the digitalis had been taken, he began to suffer with intense cephalalgia, located in the left side of the frontal region, and at the same time there were troubles of vision. The patient saw bright specks dancing before his eyes, and even figures of all sorts of animals. Two days after this, again he was seized with aphasia, which continued for four days, then ceased. After this the cephalalgia disappeared and the visual disturbances gradually subsided. The recovery, Dr. Martin thinks, was attributable to the poor quality of the digitalis rather than to any remarkable powers of resistance to the poison on the part of the patient.

TUMOR OF PONS VAROLII.—M. T. Miles, M. D. (Archives of Medicine), writes: Female, aged seventeen. Well-marked cross paralysis. Complete paralysis of left side of face (involving the orbicularis and frontalis) and of the right arm; incomplete paralysis of right leg. Sensation abolished in left half of face, conjunctiva, and nostril; much impaired in the right upper arm;

diminished in the right leg. Hearing of left ear impaired. Paralysis of all the muscles of the left eye; inflammation of left cornea.

*Post-mortem.* Externally the pons appeared enlarged and nodulated, the left side especially; the peduncles, especially the left, showing the same appearance. On section it was seen there was a growth occupying the left half of the pons, pushing the raphe to the right.

**ETIOLOGY OF ELEPHANTIASIS ARABUM.**—Max Bockhart gives the history of a woman who came to the Hospital at Wurzburg suffering from a severe attack of erysipelas, with which the patient was seized on 25th August, 1882. By 4th September she was nearly recovered from her trouble. In October of the same year she returned, complaining of a swelling in the leg previously affected. In January, 1883, the diagnosis of elephantiasis became certain. The microscope showed the lymph channels to be blocked up; the appearance was that of adenitis. In this case there is no doubt of the fact that the attack of erysipelas caused the elephantiasis.

**RESORCIN IN MALARIA.**—Dr Bassi (*Med. Ital. Pro. Veneti*) has tried this remedy in twenty cases of intermittent fever. In seventeen, success was marked; in the other three, the drug failed, as did quinine and arsenic, tried later. Resorcin was given in doses of from two to three grams, one half hour to one hour before the time for the chill. Larger doses do no more good than these, and seem to exhaust the patient. The drug causes ringing in the ears. Resorcin seems to have about the same value as quinine in this disease, but it has the advantage of being cheaper.

**THE PERMANENT BATH IN THE TREATMENT OF SURGICAL DISEASES.**—In cases after operation in which the ordinary antiseptic dressings can not be conveniently applied, owing to the location or other conditions of the wound, Dr. Sonnenberg advises

a return to the permanent bath. He has met with considerable success by this treatment after operations upon the urethra, rectum, or uterus, or in lithotomy. In the after-treatment of amputations or resections he has found it also useful. The addition of antiseptic substances to the water of the bath, he considers to be unnecessary. (Medical Record.)

MIGLIORANZA ON INTRAVENOUS INJECTION OF MILK, BLOOD, URINE, BILE, AND OTHER SUBSTANCES.—In 1873 Albertoni proposed the injection of whey in cholera; almost simultaneously, Hadder successfully, in three out of four cases of cholera, practiced the transfusion of milk. Thomas, of New York, proposed to substitute the transfusion of milk instead of blood, as being more safe and even more nutritious than blood. Lewis and Marvand asserted that milk need not be digested to be assimilated, but passes as such from the stomach into the circulation. This, Dr. Miglioranza, in accord with most physiologists, denies. (*Gazz. Med. Ital. Lombarda.*) Milk, like sugar and starch, which are changed into glucose, and albuminoids, which are converted into peptones, must be subjected to the processes of digestion before they can be of use as an aliment. Hence, it is an error to propose the transfusion of milk instead of blood. When milk (undigested) is transfused, the fatty and albuminoid constituents pass out by the kidneys and do not serve as nutriment. The sugar escapes in part in the saliva. The presence of a considerable quantity of undigested milk in the blood causes vomiting, diarrhea, prostration, and even death. The fat collects in the kidneys, and produces fatty infiltrations and chyluria. In cholera, therefore, it is better to inject whey only; in anemia, the injection of milk can not be of service. The secretion of urine depends on the state of the blood-pressure in the Malpighian corpuscles. The increase of the blood-pressure causes the passage of colloid and albuminoid materials, and even of blood. Does therefore the fatty filtration by the urine, after transfusion of milk, depend on increased blood-pressure caused by the introduction of liquid into the circulation? The solution

of this question may help to explain some cases of chylous and albuminous urine. The author finds that the blood-pressure in the capillary circulation of the kidney is not augmented, and that the filtration takes place in a state of diminished pressure; he concludes that the chyluria and albuminuria in certain morbid states may depend on stasis and relaxation of the vessels. The sudden addition of a considerable quantity of milk to the circulation causes a fall in the blood-pressure and considerable collapse in systolic force. Milk must be carefully filtered before its transfusion, so that the butter and milk globules, some of which are much larger than blood-corpuscles, may not give rise to obstructions in the pulmonary or cerebral capillary circulations. The transfusion of milk is always dangerous; whey may be used as Albertoni suggested; he injected ninety to one hundred grams into the veins of dogs without harm. This shows that the danger in injection of milk is not from the quantity of fluid. The undigested casein is transformed into urea, and appears as such in the urine, and therefore is of no use as an aliment. Thomas's argument was founded on the resemblance of milk to chyle, but they are really very dissimilar. In his experiments his animals did not suffer, because he only injected very small quantities of milk.

*Transfusion of Blood.* The best method is that of *homogeneous and direct transfusion*, that is, the transfusion of arterial blood of one animal into the vein of another of the same species without exposing the blood to the air. *Indirect transfusion of defibrinated heterogeneous blood.* Blood not defibrinated would quickly coagulate in the veins and cause death. The author's experiments confirm the condemnation of the method by which blood of an animal of a different kind is defibrinated in an open vessel and injected by a syringe. When a considerable quantity of blood is suddenly injected into the circulation, great plethora and intravasal pressure results; but if a corresponding amount be first taken away, the injection is well borne. This points to what is the essential indication for the transfusion of blood. Where there has been great hemorrhage, the transfusion of

defibrinated blood, even of an animal of a different species, is of the greatest benefit. Even in these it is not invariably successful; in one experiment the animal, after apparently doing well for three days, died of melena. This is always liable to happen after transfusion of heterogeneous blood. Prof. Giannuzzi found that, of two dogs equally reduced by starvation, that one died first in which repeated transfusion of blood was practiced.

The author's next series of experiments were to determine the effects of the *intravenous injection of urine*. It is of the greatest practical interest to determine whether the symptoms of uremia are due to the accumulation of the principles of urine in the blood or to the products of the decomposition of urine. He found that normal recent urine, even from an animal of different species, when injected in considerable quantity, gives rise to no symptoms of uremia, the only effect being slight increase of pulse and respiration from the temporary increased blood-pressure. This, again, shows that the danger in injecting milk is not owing to the quantity injected increasing the blood-pressure, but must arise from the heterogeneous nature of the undigested milk. The components of urine exist preformed in the blood, while those of milk do not. After lithotomy, the urine bathes the raw surface of the wound without harm; so, too, as is well known, urine is an old popular remedy for ulcers, wounds, etc. In disease of both kidneys, or where they are extirpated, the elimination of urea is arrested, the tissues can no longer unload into the blood the urea of their own interstitial juices, and their functions are paralyzed. Then arises a state of uremia (urine accumulated in the blood) with mixed irritative and paralytic phenomena affecting the nervous, muscular, and gastro-enteric systems, which are encumbered with urinary elements; hence vomiting, diarrhea, convulsions, and coma. But these phenomena do not depend on direct poisoning of the blood by the normal components of the urine. The injection of fifteen grams of urea into the femoral vein of a dog weighing eight kilograms gave rise to no symptoms. When carbonate of

ammonia is injected, it gives rise to all the symptoms of uremia, tetaniform convulsions, distress of breathing, hurried circulation, hyperesthesia, lethargy. When urine in the ureters or bladder undergoes ammoniacal fermentation, the blood takes up the ammonia, and these symptoms are developed.

*Intravenous injection of bile* was next studied. The principles of the bile do not exist preformed in the blood, as do those of urine. A distinction must be made between the effects of suppressed secretion of the bile from the blood and the effects of the re-absorption of bile already formed in the liver. The effects of suppressed secretion can not be studied experimentally, as the liver can not be extirpated without causing death. In dogs, the symptoms produced by injecting bile into the blood are prostration of strength, hurried breathing, salivation, vomiting, and *dilatation of the pupil*. The injection of fifty grams caused death at once. These symptoms are analogous to those of icterus from re-absorbed bile (from obstruction of the common bile duct). Guglio maintains that some of the principles of bile are re-absorbed, and meet some physiological want in the blood; but the author's results prove that all these principles are harmful. The salts of the bile are decomposed in the intestines into cholic acid, etc., which are insoluble in water.

Cholesterine exists in constant but very minute proportions; it is considered as a nervous detritus; in excess it causes a dyscrasic and infective malady, cholesteremia (Flint and Salisbury). Professor Lussana attributes to it a special and important influence in miliary fever. When injected into the blood it is much more deleterious than any other principle of bile. It seems strange that a substance which is contained in blood and bile, although in minute proportions, should give rise to such dangerous symptoms. Another example of the same sort is found when Liebig's extract of beef is injected. In three out of four experiments of the author's with *extractum carnis* the animal died; and this is not owing to the presence of ptomaines, which are products of putrefaction, but merely to the state of undue concentration. Professor Lussana asserts that some



poisons are eliminated with the bile. The author made several experiments with carbuncular virus. He found that this, at all events, is not eliminated with the bile.

*Intravenous Injection of Aromatics.* Essential oils, enanthic ether, etc., if much diluted, are stimulant only. The fatty acids in very small quantity are physiological excitants; and a larger quantity, like urea, cholesterine, etc., causes death.

*Intravenous Injection of Alcohol and Aldehyde.* Alcohol can exist in the blood without coagulation even in as large a proportion as 1 to 300, and this proportion is not necessarily fatal. The injection of 1 to 1,000 produces the phenomena of intoxication. The effects of alcohol are more potent in man. The symptoms of acute alcoholic poisoning are attributed to the transformation of alcohol into aldehyde, which is much more pernicious than alcohol. Sensibility, motion, and respiration are paralyzed, while the heart's action may still preserve its energy. Probably the cases of acute alcoholic poisoning of asphyctic form are to be attributed to this transformation of alcohol into aldehyde. (G. D'Arcy Adams, M. D., in London Medical Record.)

**EUCALYPTUS IN THE TREATMENT OF ACUTE TONSILLITIS.**—Dr. Houston has used eucalyptus in cases of quinsy with very gratifying results. Dilute one dram of the fluid extract with one ounce of warm water, and use as a gargle or spray every twenty minutes. The water must be as warm as the patient can bear it. All the cases so treated recovered speedily, without suppuration. No other remedy was used, except in one instance, when quinine was prescribed.

**PERSISTENT HICCOUGH CURED BY SUBCUTANEOUS INJECTIONS OF PILOCARPIN.**—Dr. Ruhdorfer, of Götzendorf, relates the history of a girl, nineteen years of age, who, for three months, suffered from an obstinate hiccough. All kinds of sedatives were employed in vain. Subcutaneous injections of pilocarpin, gr. ss, in ℥ xv. of water, finally gave relief. Stadler has reported similar case cured by the same means. (Medical Record.)

ETIOLOGY OF SUPPURATION.—It has been said by some that suppuration only occurs in the presence of microzymes; others, again, hold that it may occur in their absence. In order to decide this question, Dr. Councilman has made some experiments in Professor Cohnheim's laboratory. The result of these experiments, in which he thinks that the entrance of micro-organisms from without has been certainly excluded, is that their presence is not necessary to produce purulent inflammation, for that certain chemical bodies, for example croton-oil, can do this. (*Virchow's Archiv.*)

SOLIDIFIED CREOSOTE FOR TOOTHACHE.—Creosote is a popular remedy much in use for toothache and caries of the teeth. Its fluidity sometimes causes serious oral accidents, but that can be remedied by solidifying it with collodion—two parts of collodion to three parts of creosote. A gelatinous mass is thus obtained which is plastic and with which the cavity of the tooth can be obdurate, which prevents the access of air, and influences the dental nerve. (*Revue de Ther.*)

THE EFFECT OF LIME-JUICE ON THE MENSES.—A contributor to the *Lancet* states it as a fact that the sucking of the juice of one or two lemons by women suffering from an inordinate flow of the menses has the effect of checking the same. This statement, in connection with the reports of the effect of lime-juice upon the amative instincts of the male, would seem to tend to establish a belief in its anaphrodisiac properties. (*Therapeutic Gazette.*)

PEROSMIC ACID is a new remedy employed by Prof. Winiwarter in cancerous and scrofulous swellings. It is used by injecting daily three drops of a one-per-cent solution of the acid, which treatment causes the tumor to soften and decrease in size; the dead tissue is thrown off and disappears in about a month. No curative effects upon cancer itself have been observed from the remedy. (*Rundschau, Leitm.*)

AN UNUSUAL CAUSE OF GASTRO-INTESTINAL IRRITATION IN A CHILD.—Prof. G. G. Roy, of Atlanta, Georgia, details, in the Southern Medical Record, the particulars of a case of severe gastric and intestinal disturbance simulating cholera infantum, in which, after treatment by castor oil, spirits of turpentine, and whisky, the cause of the irritation was ejected from the bowels of the patient—a child about twenty months old—and found to be a mouse, nearly full grown, which had been swallowed a day or two before.

TINEA VERSICOLOR.—Oleate of copper, in the form of ointment, is very successfully used in the cure of this complaint at the Philadelphia Hospital for Skin Diseases.

### **Notes and Queries.**

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THE NEW YEAR.—There is an old, and rather a poor joke, of a trotting-horse that passed the mile-stones on the road so rapidly that his driver thought he must be riding through a cemetery. Yet, as we grow older, the new years come closer and faster together—just like those mile posts—leaving no sort of doubt that, if we are not driving through, we are constantly driving toward the Cemetery. We write it with a big C; for, alas! with each recurring annual round it grows bigger and bigger and holds a more and more important relation to the life of every one of us.

This is not a joke. It may indeed seem so to young doctors, for youth can not help thinking itself immortal. But doctors form no exemption to the rule which fixes a limitation upon human life. More's the pity! We can relieve the pain-stricken. We can strengthen the weak. We can prolong the life of others. But we are as powerless as the rest of the world to subject ourselves to our own counsels and regimen; which is to say, we are mortal, like the rest.

Yet may doctors be of good cheer, and the art of doctoring flourish long in the land which the Lord our God has given us. There is much to make us happy and proud. Of all the ages, we live and glorify the noblest, the greatest, and the best. Of all the triumphs of all the ages ours have been the most beneficent to man. In development and in progress we are abreast with philosophy, state-craft, and letters. Suppose we are personally driving toward the Cemetery? Shall we be afraid? We are sure to find good company there.

There is but one thing of which we should be afraid. That is the hardening process which so often accompanies old age. Some doctors, like wine, improve with time. Some remain

the same. Not a few grow cold and careless and cynical. A sweet old man is like a ripe apple. A sweet old doctor is like a ripe apple glorified. Old doctors, go and study the virtues of the apple-tree. Young doctors, go and emulate your elders.

Ah, well-a-day! Time does pass. "It is," said the delicious Artemus, "a way which time has." In youth, the trotter could not go too fast for us. As we gain in worldly gear, we fain would draw the rein.

What matters it? "They sang," says the divine Sappho, "whilst they drank from the poisoned chalice." So shall we; for is not all human wear and tear and care and sorrow but a poison? So drink, drink, good men and true, of the best and purest wine of life. To-morrow, to-day will be yesterday; but in the Hereafter all days shall be the same.

The New Year's greeting, aye, and the New Year's blessing—for the PRACTITIONER is e'en old enough to give a blessing—is the first word which we send out to those who love us—and that peace which passeth understanding, at least their understanding, to those who hate us, if there be any such—and so, to one and all, good morrow, dear friends.

OUR NEW DRESS.—The publishers of the AMERICAN PRACTITIONER have celebrated the incoming year by giving the journal a heavier and better paper. For our part, we had grown familiar during the fourteen years that we used it, with what we are now to give up, and had come to feel attached to. But we yield to the inevitable, and if our readers are but pleased with the change we shall be. It must be allowed that our toggery is very brave, but then it is simple, stout, durable, and clean, resembling in this, we would fain hope, what it contains.

The departure means prosperity with the publishers, and this is a matter for congratulation all round. When business prospers, doctors should prosper with it.

The change entails upon us increased effort to supply what is newest, soundest, truest, and best in both doctrine and practice, and holding the head of the journal straight in the course on

which it started to the bell-tap in 1870. This we shall do, and, by your leave, in our own way. If you like our gait, applaud us by staying with us to the finish. If you would strengthen our loins, gird them by sending us short papers on practical subjects on just such matters as you see every day of your lives. And thus shall you strengthen the loins of others also, of others doing like work at other points. If you would both quicken our pace and make it easier withal, send us a lot of new paying subscribers—we want none other—and thus shall you strengthen yourselves also, and in the same instant advance legitimate medicine in that you increase the power and extend the fame of a journal which draws its inspiration from practitioners, by practitioners, for practitioners.

AN OBSTETRIC ADVENTURE.—Dr. Pierre, in the *Gazette Medicale de Picardie*, relates the following obstetric adventure :

I was on duty at the Hospital St. Antoine. One night, about one o'clock, I was awakened to receive a patient. She brought with her in her arms an infant that was nearly naked. I received her as an urgent case. The next day she gave me her history; but I will let her speak for herself. "I am a very gay person, sir. I love the ball. I have not absented myself during my pregnancy, which yesterday passed the seventh month. At ten o'clock last evening I was one of the first at the dance, near the da Trone. I did my best. After several country dances I felt pains. So much the worse, said I, if it is coming this evening, as I have not reached my full time. I will leave this ball as late as possible. But the pains continued. The more I suffered the more I danced. In the *cavalier seul*, which at our balls leaves the ladies to dance alone, seized with sharp pains, I made some astonishing contortions while dancing. I had a remarkable success. Then the gallop followed, in which I seized my partner with a vigor I did not know I was capable of—when suddenly the waters broke. The accident was observed, but was attributed to a different cause. The jokes rained on me. I tried to escape, they pursued me. I ran out, they followed



me. I passed down the Boulevard Mazas; some thirty of them were at my heels. Where the Medi Charenton branches off, I climbed over the board fence of a wood-yard. Fortunately my pursuers had lost trail of me. I sat on the ground, it was time—the child came five minutes afterward. I have wrapped it up in my handkerchief, and, small as it is, I think it will live." She was right, both mother and child did well, and she left the hospital ten days later without any disagreeable complication.

DANGER FROM FLIES.—Dr. Grassi is said (British Medical Journal) to have made an important, and by no means pleasant, discovery in regard to flies. It was always recognized that these insects might carry the germs of infection on their wings or feet, but it was not known that they are capable of taking in at the mouth such objects as the ova of various worms, and of discharging them again unchanged in their feces. This point has now been established, and several striking experiments illustrate it. Dr. Grassi exposed in his laboratory a plate containing a great number of the eggs of a human parasite, *Tricocephalus dispar*. Some sheets of white paper were placed in the kitchen, which stands about ten meters from the laboratory. After some hours, the usual little spots produced by the feces of flies were found on the paper. These spots were examined by the microscope, were found to contain some of the eggs of the tricocephalus. Some of the flies themselves were then caught, and their intestines presented large numbers of the ova. Similar experiments with the ova of the *Oxyuris vermicularis* and of the *Tenia solium* afforded the corresponding results. Shortly after the flies had some moldy cream, the *Oidium lactis* was found in their feces. Dr. Grassi mentions an innocuous and yet conclusive experiment that every one can try. Sprinkle a little lycopodium on sweetened water, and afterward examine the feces and intestines of the flies; numerous spores will be found. As flies are by no means particular in choosing either a place to feed or a place to defecate, often selecting meat or food for the pur-

pose, a somewhat alarming vision of possible consequences is raised. Dr. Grassi invites the attention of naturalists to the subject, and hopes that some effectual means of destroying flies may be discovered. (Medical Record.)

THE SUB-UNGUEAL PULSE.—Dr. Henri Gripat, in 1873, noted a case of sub-ungueal pulse, which is considered as the first time that this phenomenon has been observed. Dr. Gripat tells us (*La France Medicale*) that he has never been able since to observe a second case, but he gives the notes of the case cited. It occurred in a young patient suffering from rheumatism of long standing, having an old aortic insufficiency, with hypertrophy and anemia, during an attack of subacute rheumatism. The pulse was regular, bounding, depressible, and could readily be seen in the arteries of middle size, as the temporal, radial, tibial, and collaterals of the fingers. On raising the fingers a little, while the hand remained flat on the bed, the blood could be seen passing briskly under the nail and coloring it red; this color disappeared almost immediately and the nail became white in its center, remaining red only at its periphery. The coloration was transient, intermittent, pulsatile, and systolic. (Journal American Medical Association.)

A CASE OF CYSTICERCUS IN THE BRAIN OF A CHILD ONE YEAR OLD.—The London Medical Record says that Dr. O. Soltman (*Centralbl. für die Med. Wiss.*) relates the following case: A child, one year old, was seized with vomiting, convulsions, and squinting, and suddenly died. The post-mortem examination revealed a rickety state of the osseous system. In the middle of the gray substance of the gyrus fornicatus was found a tumor of the size of a pea (a cysticercus); one also in the left corpus dentatum, and two smaller tumors in the cortex of the left posterior lobe on its under surface, near the fissura calcarina. No teniæ were found in the intestines. The author finds only one case of this kind at so early an age. Fleischmann records a case of cysticercus in the brain of a child two years old. (Medical and Surgical Reporter.)

A LESSON FOR ANTI-VACCINATORS.—The following item is copied from the London newspapers. It presents a subject for profitable meditation by the foes of vaccination: A master manufacturer of boots and shoes in London, who had made himself conspicuous by his opposition to vaccination, hung himself through remorse a short time ago. He had recently lost his wife and three children by smallpox, and it was alleged at the time that not only was this terrible loss due to his anti-vaccination opinions, but that through his carelessness several persons caught the infection and one young man died.

COLD ABSCESS OF THE TONGUE.—A woman, aged thirty-five, with a swelling on the right side of the tongue, presented herself. The tumor was the size of a walnut, soft and fluctuating, and not painful on pressure or manipulation. It had appeared without known cause four months previously, had attained its present size in one month, and then remained stationary. The patient's general health was excellent. Dr. De Brun incised the tumor and gave exit to a quantity of thin pus. The sac was dissected away, and the wound closed with sutures. Union was complete in a few days. (*Médicale.*)

IN A CASE OF HEMORRHAGE FROM THE INTERCOSTAL ARTERY, from homicidal stabbing, I arrested the flow immediately by making pressure within the pleural cavity, directly on the vessel, by introducing into the wound the handle of a door-key. The key was then turned transversely, so as to make direct pressure, and maintained in that position for some hours, until there was no more tendency to hemorrhage. The same mechanical action might be effected by the similar use of the handle of an ordinary gimlet. (Dr. Levis, Philadelphia.)

PROFESSOR JACCOUD.—By a presidential decree from the *Faculté de Médecine*, of October 6th, Prof. Jaccoud has been transferred from the Chair of Internal Pathology to that of Clinical Medicine, made vacant by the death of Prof. Lasègue.

PORRO'S OPERATION.—Dr. Boni recently performed this operation, at the St. Nicholas Hospital at Arezzo, for grave rachitic deformity, profuse hemorrhage coming on from rupture of the membranes and threatening life. The patient was in excellent condition on the seventeenth day after the operation.

Prof. Antonio Martino has also performed the operation quite recently, at the Maternity Hospital in Naples, for rachitic deformity. Both mother and child were saved. (*L'Indipendente.*)

WE learn that a journal has been started in Paris, called the Daily Medical Journal. As its name indicates, it is to give daily information of the progress of medicine. The subscription price is forty francs a year. The establishment of a similar journal in this country might go very far toward satisfying the wants of those practitioners who feel restricted in not being allowed to advertise in the daily papers. No objections could be raised to advertisement in a daily medical journal.

#### OLD SHOES.

How much a man is like old shoes!  
For instance, both a soul may lose;  
Both have been tanned; both are made tight  
By cobblers; both get left and right;  
Both need a mate to be complete,  
And both are made to go on feet.  
They both need heeling, oft are sold,  
And both in time all turn to mold.  
With shoes the last is first; with men  
The first shall be last; and when  
The shoes wear out, they're mended new;  
When men wear out they're men-dead, too.  
They both are trod upon, and both  
Will tread on others, nothing loath.  
Both have their ties, and both incline  
When polished in the world to shine:  
And both peg out—and would you choose  
To be a man or be his shoes?

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